

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/24/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVER CROSSING ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 MARKET ST</b> <b>CHARLESTOWN, IN 47111</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00182295.</p> <p>Complaint IN00182295 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Date: September 24, 2015</p> <p>Facility number: 012007 Provider number: 012007 AIM number: N/A</p> <p>Census bed type: Residential: 101 Total: 101</p> <p>Sample: 3</p> <p>River Crossing Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00182295.</p> <p>QR was completed by 99993 on 09/25/15.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE